General Protocol # 1

Orders For All Patients

I. SCENE SIZE-UP

Assess:

- Need for body substance isolation
- Scene Safety
- Trauma (MOI) or Medical (NOI) nature
- Number of patients

II. INITIAL ASSESSMENT

General Impression of Patient

- Chief complaint, trauma or medical, age and sex
- Check for obvious life threatening problems.

Level of Consciousness

- Spinal immobilization (if needed) and AVPU (Alert, Verbal, Painful, Unresponsive)

Airway Status Assessment

- Responsive Patient: Is breathing adequate? (Normal rate 8-24)
- Unresponsive Patient: Is airway open? If not, open and clear

Breathing Assessment

- Responsive Patient: If adequate, consider oxygen
- Unresponsive Patient: If adequate, apply oxygen, consider airway adjuncts
- If inadequate, assist ventilations, apply oxygen, use airway adjuncts

Circulatory Assessment

- Rapid pulse check, bleeding check, skin CTC (color/temperature/condition)
- Capillary refill check (< 2 seconds is normal) Use for children < 6 years only)

Identification of Priority Patients

- Stable/Unstable, Transport Decision, Need for Advanced Life Support back-up
- Poor general impression
- Unresponsive patient – no gag or cough
- Responsive – not following commands
- Difficulty breathing
- Shock (hypoperfusion)
- Complicated childbirth
- Chest pain with BP <100
- Uncontrolled bleeding
- Severe pain anywhere

III. FOCUSED HISTORY AND PHYSICAL EXAM (Rapid Assessment)

<u>Mechanism of Injury (MOI)</u>

ALL PATIENTS:

- Ejection from vehicle
- Death of another passenger
- Fall over 20 feet
- Roll over of vehicle
- High speed vehicle crash

Motorcycle crash
Unresponsive or altered mental status
Penetrations of head/chest/abdomen
Hidden injuries (seat belt/airbag)

INFANTS AND CHILDREN:
Falls over 10 feet
Medium speed vehicle crash
Bicycle crash

Nature of Illness (NOI) – Medical
Assess complaint, signs and symptoms (O,P,Q,R,S,T)

O = Onset (When/How did symptoms start?)
P = Provocation (What caused or makes symptoms change?)
Q = Quality (Describe symptoms/sensations/pain)
R = Radiation (Does sensation move to other body area(s)?)
S = Severity (How severe is discomfort? Scale of 1-10)
T = Time (How long have symptoms lasted?)

IF UNRESPONSIVE OR PRIORITY NOI:
Reassess airway and airway protection
Perform Rapid Assessment

RAPID ASSESSMENT – If unresponsive or priority mechanism of injury/nature of illness
Reassess mental status
Spinal stabilization
Head-To-Toe Exam (DCAP/BTLS)

D = Deformity
C = Contusions
A = Abrasions
P= Punctures/Penetrations
B = Burns
T = Tenderness
L = Lacerations
S = Swelling

ROLL PATIENT TO ASSESS POSTERIOR BODY

ASSESS BASELINE VITAL SIGNS
Breathing: Rate, Rhythm, Depth
Pulse: Rate (Rapid/Slow), Quality (Strong/Weak – Regular/Irregular)
Pupils: Size (Normal/Dilated/Constricted) Equal size? Reactivity (Reactive/Non-reactive)
Equal reaction?
Blood Pressure: (Systolic/Diastolic) All patients over 3 years old
Capillary Refill: (<2 seconds is normal) Use for children <6 years old ONLY

ASSESS SAMPLE HISTORY

S = Signs and Symptoms
A = Allergies (Medications, food, bee stings, etc.)
M = Medications (Prescribed or over –the-counter)
P = Past Pertinent Medical History
L = Last Oral Intake (Fluid or Solid)
E = Events leading to history of present illness (HPI)

IV. DETAILED ASSESSMENT

Complete Head-To-Toe Assessment – Perform full body assessment of areas not previously examined. Purpose is to identify previously unknown wounds/injuries and manage secondary problems.

Assess head (DCAP/BTLS)
Assess neck (DCAP/BTLS, jugular vein distention, crepitation
Assess chest (DCAP/BTLS, paradoxical motion, crepitation, breath sounds
Assess abdomen (DCAP/BTLS, swelling, firm/soft
Assess pelvis (DCAP/BTLS, if no pain – compress
Assess extremities (DCAP/BTLS, pulse/motor/sensation
Assess posterior body (DCAP/BTLS)

Performance is patient and injury specific – used to gather more detailed patient information in addition to Initial and Focused Assessments. Patient injury/illness will guide EMT as to whether to perform this assessment or not. (Performed only after priority treatments have been performed and patient condition and team member availability allows.)

V. ON-GOING ASSESSMENT

Reassess mental status
Monitor airway status
Monitor breathing
Reassess pulse (rate/quality)
Monitor skin CTC (color/temperature/condition)
Adjust patient priorities as needed
Reassess vital signs
Repeat Focused Exam regarding complaint or injuries
Check interventions

Stable patient: repeat every 15 minutes
Unstable patient: repeat every 5 minutes